Clinical Practice Statement:

AAEM Response to CMS 2009 Revision of Anesthesia Services Interpretive Guidelines

Reviewed and approved by the AAEM Clinical Practice Committee.

Chair: Steven Rosenbaum, MD

Authors: Mitchell Heller, MD

Sergey Motov, MD

Steven Rosenbaum, MD

J. Jeremy Thomas, MD

Reviewers: Will Meurer, MD

Robert Sherwin, MD

Michael Winters, MD

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On December 11, 2009, the Centers for Medicare and Medicaid Services (CMS) published revised Hospital Anesthesia Services Interpretive Guidelines. These guidelines apply to the Conditions of Participation of hospitals in Medicare. The American Academy of Emergency Medicine (AAEM) Board of Directors is particularly concerned with the provision stating,

> *All services along the continuum of anesthesia services provided in a hospital must be organized under a single Anesthesia Service, which must be directed by a qualified physician and consistently implemented in every hospital department and setting that provides any type of anesthesia services.*

The guidelines state that the Emergency Department is explicitly included in this provision.

"Anesthesia services" are broadly defined within the guidelines as "both anesthesia and analgesia…ranging from the application of local anesthetics for minor procedures to general anesthesia for…invasive operative procedures." From the point of view of a regulatory bureaucracy, it is understandable that CMS would prefer that there be a single point of responsibility and a single standard of care for procedures as widely performed and dispersed throughout a hospital as anesthesia. However, it is the position of the AAEM Board that the imposition of such a single standard, determined by a non-emergency physician, will impede the

safe, effective, and efficient provision of care for patients by Emergency Physicians (EP) in the Emergency Department (ED).

The practice of Emergency Medicine (EM) has drawn knowledge and procedural practice from virtually all medical specialties. EPs suture wounds, cardiovert cardiac arrhythmias, reduce orthopedic dislocations, provide analgesia and anesthesia, etc. EM is subject to unique circumstances and constraints: the unplanned, non-elective provision of care; the traumatic nature of wounds and acuity of injuries; the need to manage multiple critical patients simultaneously; the need to rapidly stabilize and disposition acutely ill or injured patients. These constraints are rarely if ever applied to other practices. As a result, EPs have adapted and modified the procedures of other medical and surgical practices.

To the lay observer (and even many non-emergency physicians) our practices may appear identical to the practices of other specialists. This is a critical misunderstanding. Emergency Physicians suture wounds with techniques adapted from but not identical to surgeons. EPs care for cardiac problems with techniques adapted from but not identical to cardiologists. EPs provide analgesia and anesthesia with techniques adapted from but not identical to anesthesiologists. Our adaptations are vitally important to the provision of safe, effective and efficient care to our patients.

The Emergency Medicine techniques for anesthesia and analgesia are taught in accredited EM residency programs. Anesthesia and analgesia for EPs are regular subjects for continuing medical education at EM conferences and at courses dedicated to the topic. Research in EM analgesia and anesthesia is the subject of a robust peer-reviewed EM literature.

The unique nature of our approach to diagnosis and treatment is the very reason for the creation and recognition of Emergency Medicine as a specialty practice with its own board certification. For this reason, it is no more acceptable to have non-emergency physicians set standards or determine practices for EM than it would be to have cardiologists set standards or determine the practices of gastroenterologists.

Following the logic of CMS with regard to a single, hospital-wide standard for anesthesia services to be applied to the ED, one would have to argue that cardiologists should determine the standards and practices in the ED for the management of hypertension and arrhythmias, pulmonologists should determine how to manage acute asthma exacerbations in the ED, etc. The consistent application of this line of reasoning would amount to the deconstruction of Emergency Medicine and the complete abandonment of the modern concept of a unique, integrated practice of emergency care.

CMS has explicitly adopted the practice guidelines of the American Society of Anesthesiologists (ASA). However applicable these guidelines may be to the practice of anesthesiology, they are not appropriate for the practice of EM. For instance, anesthesiologists generally perform Rapid Sequence Induction (RSI) for the purpose of providing general anesthesia during a surgical

procedure. By contrast, EPs perform RSI for the purpose of gaining control of a critically ill patient's airway with no intention to subsequently perform general anesthesia. The ASA guidelines distinguish (and CMS emphasizes the distinction of) various types of anesthesia such as "monitored anesthesia care", "moderate sedation/analgesia", and "minimal sedation". These distinctions are not useful or meaningful in the ED. The EP chooses the type and dosing of sedative and analgesic drugs based on the patient and the procedure to be performed, not on some abstract "type" of anesthesia. Attempting to force EM into the practice model of anesthesiology makes no more sense than requiring that cardiologists practice within the practice model of emergency medicine.

For all of the foregoing reasons, it is the position of the AAEM Board that the revised Hospital Anesthesia Services Interpretive Guidelines requirement for a single, hospital-wide Anesthesia Service applied to the Emergency Department are inimical to the practice of Emergency Medicine and represent an impediment to the safe, effective and efficient care of Emergency Department patients. The AAEM Board calls upon CMS to revise the guidelines to recognize the unique practice of Emergency Medicine subject to standards set by Emergency Physicians.